**FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE**

We would like to thank you for choosing South Coast Health Center for your primary care needs and look forward to working with you to achieve your goals. We ask for your assistance in reviewing and understanding our payment policy. If you should have any questions, please do not hesitate to ask, we are more than happy to help you. After you have reviewed the policy *please complete and sign the registration on the other side.*

* Co-pays are due at the time of service
* We accept cash, personal checks, MasterCard, Visa and Discover
* We will be happy to help you process your insurance claim form for your reimbursement
* We do accept assignment
* We realize that temporary financial problems may arise affecting timely payment of your account. Please contact our office manager if problems arise, we will be delighted to work with you.

By signing, you agree to:

* Pay any and all charges that are not otherwise paid by your insurance carrier. These charges could include amounts applied to your annual deductible, co-payment amounts, and charges denied as not covered by your insurance program or deemed medically necessary.
* In the event your account should be referred to a collection agency or lawyer for collection, you agree to pay any and all collection fees and or court costs.

Your therapist will gladly discuss your proposed treatment with you, but all questions relating to your insurance

company will be directed to the office manager.

**Please realize that your insurance is a contract between you, your employer and the insurance company.**

**We are not a party to that contract.**

**Statement of Financial Responsibility**

South Coast Health Center is concerned about your health. We look forward to assisting you with your health care issues. Please remember that your health insurance is your responsibility, but we can help. Regardless of what we might calculate as your healthcare benefit in dollars, we must stress the fact that you, the patient, are responsible for the total treatment fee. As a courtesy to you, we can accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. We allow 30 days for your insurance company to make a payment. After that time all inquiries or follow up in payments due become your responsibility.

Patient/ Guarantor Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_

IF YOU RECEIVE MEDICARE, PLEASE READ THE FOLLOWNG, SIGN, AND, DATE

**PATIENTS MEDICARE AUTHORIZATION**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Medicare Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that payment of authorized Medicare benefits be made on my behalf to:

**South Coast Health Center**

**29641 Ellensburg Ave.**

**Gold Beach Oregon 97444**

for any services furnished me by that physicians/supplier. I authorize any holder or holder of medical information about me, to release information to the Health Care Financing Administration and its agents, any information needed determine these benefits payable to relatable services. I understand my signature requests that payments be made and authorize release of medical information necessary to pay the claim. If (other than insurance) is indicated in item 9 of the HCFA -1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

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Patient/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_